

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-001614

FILED VS JAN 25 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 130

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> , COUNTY <b>Livingston</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in lb <b>8 days</b>		c. CITY OR TOWN <b>Chillicothe</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Lukes' Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>123 Secret Chillicothe Mo</b>			
3. NAME OF DECEASED (Type or print) First <b>Goldie</b> Middle <b>Hicks</b> Last <b>Hicks</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>8,</b> Year <b>1960</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>1-2-1900</b>		
9. AGE (last birthday) <b>60</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HR				
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <b>at home</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>no.</b>		11. BIRTHPLACE (City and state or country) <b>Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>John W. Glass</b>			13b. MOTHER'S MAIDEN NAME <b>Mary E. Billings</b>			14. NAME OF HUSBAND OR WIFE <b>Charles J. Hicks</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Charles J. Hicks, 123 Secret</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Vultae</b>							INTERVAL BETWEEN ONSET AND DEATH <b>10 sept 59</b>	
Conditions, if any, which gave rise to above cause (e), stating the underlying cause last. DUE TO (b) <b>Lower Nephron Nephrosis</b>							<b>1/10/60</b>	
DUE TO (c) <b>Post operative Tuberculosis</b>							<b>1/2/60</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour <b>8:55</b> a.m. <b>A.</b> Month, Day, Year <b>1/2/60</b>								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE		
21. I attended the deceased from <b>1/2/60</b> to <b>1/8/60</b> and last saw her alive on <b>1/8/60</b> Death occurred at <b>8:55 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Harold L. Gaine MD</b>				22b. ADDRESS <b>4635 Maple St</b>		22c. DATE SIGNED <b>1/9/60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>1-8-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chillicothe Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Chillicothe, Missouri</b>		
24. FUNERAL DIRECTOR <b>Stine &amp; McClure, Kansas City, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>1-9-60</b>		26. REGISTRAR'S SIGNATURE <b>Nora Minshall</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF  
Harold L. Gaine

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Eugene T. Jensen*

Licensed Embalmer No. 463

P. O. Address Jensen

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.